NJNG YOUTH CAMP
CAMP DATES: 13-19 July 2008
JUNIOR COUNSELOR APPLICATION
FILL THIS OUT IF YOU ARE 16-17 YEARS OLD
Application Deadline 15 MAY 2008

PLEASE READ CAREFULLY AS THERE ARE MANY CHANGES!!

Please return completed application with all appropriate documents to:
Joint Force Headquarters
ATTN: Family Programs
3650 Saylors Pond Road
Fort Dix, NJ 08640

For further information, please contact the State Family Programs Office at 609-562-0636. If accepted, you will receive a confirmation packet by mail. In that mailing, you will be given a list of items to bring with you to camp.

JOB DESCRIPTION

JUNIOR COUNSELOR – MUST be available 12 – 19 July 08. Assist the Senior Counselors in the supervision, safety and motivation of each camper. Monitors all camper activities to insure health, welfare and safety issues are addressed. Junior Counselors should set an example for all campers and work to build self-esteem and teamwork. They should show care and respect for all campers and staff. Participate in all programs and activities with the campers. **MANDATORY** training for ALL counselors on Saturday July 12, 2008 at 1pm.

NAME:_____

Do you have camp experience? (circle) YES NO
If yes, explain: _____

List your areas of expertise/experience/skills:
1. _____
2. _____
3. _____

Please list any special talents or certifications you may have. _____

DO YOU HAVE A VALID DRIVER'S LICENSE? (CIRCLE) YES NO
WILL YOU HAVE A CAR AT YOUTH CAMP? (CIRCLE) YES NO
IF YES, PLEASE FILL OUT THE FOLLOWING:
MAKE: _____ **YEAR:** _____
MODEL: _____ **COLOR:** _____
LICENSE PLATE NUMBER: _____
STATE REGISTERED IN: _____

JR. COUNSELOR APPLICATION (AGES 16 & 17)
NJNG YOUTH CAMP
13-19 July 2008

NAME: _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:**_____

HOME PHONE: (____) _____ **CELL PHONE:** (____) _____

EMAIL ADDRESS: _____

AGE: _____ **DATE OF BIRTH:** _____/_____/_____

T- SHIRT SIZE (ADULT) S M L XL XXL XXXL

EMERGENCY CONTACT NAME: _____
Emergency Phone # (Day) ( ) _____(Evening): ( ) _____

Do you have any relatives who will be either attending the camp or volunteering? How many? Attending _____ Volunteering _____
Youth Name(s): _____

MILITARY SPONSOR INFORMATION

MUST BE COMPLETED !!!!!!!!

NAME: _____**Rank:** _____ **(circle) Active / Retired**

SERVICE MEMBER'S SSN: _____ - _____- _____

CURRENT UNIT: _____

RELATIONSHIP TO APPLICANT: _____

IF retired, what unit: _____ **Date Retired:** _____

Sponsor Status (Circle one): NJARNG / NJANG / NJ DMAVA Employee

Applications must be received complete including Part A and Part B of Medical Forms, copy of birth certificate and application fee. Incomplete applications will be returned and not considered for acceptance until complete. Physicals must be less then 2 years old to be valid.

PLEASE READ AND SIGN THE FOLLOWING INFORMATION!!!!!

PARENTAL AGREEMENT:

I _____, parent/guardian of _____

_____, grant permission for my child to participate in the NJNG Youth Camp as a junior volunteer. I hereby voluntarily waive any claim against the New Jersey National Guard, the department of Military and Veterans Affairs or the United States of America for any or all causes which may arise in connection with my participation or my child's participation in the NJNG Youth Camp.

Parent/Guardian Signature **Date**

I understand that the National Guard Youth Program is developing photographic and multimedia materials, which illustrate activities at the National Guard Youth Camp. I grant the National Guard Youth Program and its associated staff and subordinate entities, the right to take, use, reproduce, assign and/or distribute photographs, films, videotapes, sound recordings and non-confidential information of the youth for use in any such materials as the National Guard Youth Program or its associated entities may create, without any payment to or future approval by me. I concur that there shall be no payment for such use.

_____ _____

Child Name **Parent/Guardian Name**

Parent/Guardian Signature **Date**

NJNG YOUTH CAMP HEALTH HISTORY AND EXAMINATION FORM

PART A TO BE COMPLETED BY THE PARENT/GUARDIAN

VOLUNTEER NAME:_____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

DATE OF BIRTH: ____/_____/_____ PLACE OF BIRTH: _____

Parent/Guardian Name: _____ Relationship: _____

Telephone # Home: ( ) _____Work ( ) _____

Name, address and phone number of nearest next of kin (other than Parent/Guardian):

Name: _____ Address:_____

City: _____State: _____ Zip: _____

Phone: ( ) _____

INSURANCE CARRIER: _____

Policy # _____

HEALTH HISTORY (COMPLETED BY PARENT/GUARDIAN)	YES	NO
1. Is the child under a physician's care now?	___	___
if yes, explain _____		
2. Has this child ever been medically advised not to participate in any kind of sports?	___	___
3. Is this child medically excused from physical education at the present?	___	___
4.Has He/She…		
a. Ever been unconscious after an injury?	___	___
b. Ever had a fracture or dislocation?	___	___
c. Ever had any surgery?	___	___
d. Within the last year, had to stay in a hospital overnight?	___	___
e. Ever experienced frequent chest pains or palpitations?	___	___
f. Ever experienced high blood pressure?	___	___
Does this child. . .		
a. Have a history of fainting with exercise?	___	___
b. Have a history of tiredness/fatigue?	___	___
c. Take any medications every day?	___	___
d. Have any allergies, including bee stings, hives, asthma?	___	___
e. Have a family history of sudden unexplained death under age 40?	___	___

	YES	NO
6. Do you have any worries about his/her health or think that there may be any reason why he/she cannot participate in sports?	___	___

List any malfunctions or absence of a paired organ (eyes, kidneys, testes, etc).

8. Please list and explain any illness, injury, surgery, allergies and /or medications since his/her last physical.

9. Has your child been designated as a "special needs" child in his/her school district or defined as having "Attention Deficit Disorder".	___	___

PLEASE EXPLAIN ALL YES ANSWERS:

Signature of Parent _____ Date _____

PART B

TO BE COMPLETED BY PHYSICIAN

IMMUNIZATION RECORD

Name of Child (Last, First, MI)	**Birth Date (Mo, Day, Yr)** / /	**Sex** ☐ **Male** ☐ **Female**
PARENT/ GUARDIAN	**Name** **Phone ( )**	
	Address	

VACCINE TYPE	**DISEASE DATE**	**1ST DOSE Mo/Day/Yr**	**2nd DOSE Mo/Day/Yr**	**3rd DOSE Mo/Day/Yr**	**4th DOSE Mo/Day/Yr**	**5th DOSE Mo/Day/Yr**	**6th DOSE Mo/Day/Yr**
Diptheria, Tetanus, Pertussis - DPT *if DT or TD, indicate in corner box		☐	☐	☐	☐	☐	☐
Oral Polio Vaccine (OPV) if Salk Vaccine, Indicate (IPV) in corner		☐	☐	☐	☐	☐	☐
MMR (Measles, Mumps & Rubella)							
Measles					Measles or Serology	Date	Titer
Rubella					Measles or Serology	Date	Titer
Mumps					Measles or Serology	Date	Titer
Hepatitis B						Date	

DT Requires valid medical exemption	Provisional admission attached ☐ Date Granted:	Medical exemption attached ☐	Religious exemption attached ☐

TB Screening (Mantoux Test)	Date	Date	Date
Tested	_____	_____	_____
Read	_____	_____	_____
Result (MM)	_____	_____	_____

Chest X-Ray Date	Result Normal	Abnormal
_____	_____	_____
_____	_____	_____
_____	_____	_____

Therapy
Case ☐ Reactor ☐
Date Started _____
Date Completed _____

HEALTH CARE RECOMMENDATION BY LICENSED PHYSICIAN

** I have examined the above camp applicant **within the past two (2) years**
Date Examined: _____/_____/_____

In my opinion, the above applicant ____is ____is not fit to participate in an active camp program.

The applicant is under the care of a physician for the following condition: _____
_____

Current Treatment (Include current medications, attached medication form): _____
_____

Explanation of any reported loss of consciousness, convulsion or concussion: _____
_____
Does applicant have epilepsy? Yes _____ No _____ Diabetes? Yes _____ No _____

Any treatment to be continued at camp_____
_____
Recommendations and Restrictions while at camp _____
PHYSICIAN SIGNATURE: _____ DATE: ___/_____/____
Printed Name: _____ Phone #: ( ) _____ - _____

STANDING ORDERS

for

OVER – THE – COUNTER MEDICATIONS

For NJNG Youth Camp Campers and Staff

NAME: _____

ALLERGIES: _____

BENADRYL	12.5 mg 1-2 tabs PO q6 hours, as needed.
TUSSAFED	Ex.Srup 1 Tsp. PO q6 hours as needed
TYLENOL	325 mg 1-2 tabs PO q4 hours PRN headache, temp >101, generalized pain.
MOTRIN	200 mg 1-2 tabs PO q6 hours PRN headache, temp >101, generalized pain.
MYLANTA	over 48 pounds: 1-2 tabs (or 1-2 tsp) PO q1 hour PRN upset stomach, gas. DO NOT EXCEED 6 tablets (or 6tsps) per 24 hours.
TUMS ULTRA	1-2 tabs PO q1 hour PRN upset stomach, gas. DO NOT EXCEED 6 tablets per 24 hours.
1%HYRDRO-CORTISONE CREAM	Apply to affected area sparingly BID PRN itch.
PEPTO-BISMAL	1-2 tabs PO PRN upset stomach

Physician Signature: _____ Date: _____

Print: _____

Legal Guardian Signature: _____Date: _____

Print: _____

Dear Parent or Guardian,

1. No medication, prescription or non-prescription drugs (cough drops, aspirin, Tylenol, etc.) will be given to a child by the nurse unless it is received in the original container and accompanied by a written physicians **and** parental/guardian request.
2. All medications are to be held in the nurse's office with the parent/guardian assuming the responsibility for delivering such and picking up unused amounts when no longer needed.
3. Prescription medication **must** be in the original pharmacy-labeled container.
4. Opportunities must be provided for child/parent/physician/nurse communications.
5. The physician must be consulted by the nurse whenever necessary to discuss medications being given to anyone under the age of 18 including long-term use and possible abuse of any over-the counter medications.
6. **No volunteer under the age of 18** will be allowed to medicate him/herself during the camp.
7. **JUNIOR AND SENIOR COUNSELORS ARE REQUIRED TO REPORT TO SEA GIRT FOR MANDATORY TRAINING ON SATURDAY 12 JULY 2008 AT 1PM.**

Please return completed application with all appropriate documents to:

Joint Force Headquarters
ATTN: Family Programs
3650 Saylors Pond Road
Fort Dix, NJ 08640

For further information, please call State Family Programs Office at 609-562-0636.

PERMISSION TO MEDICATE FORM

An authorization form is required to be signed by the physician and the parent/guardian of any child or volunteer under the age of 18 who must receive medication during camp.

NAME OF VOLUNTEER: _____

NAME OF PHYSICIAN: _____

NAME OF MEDICATION: _____

_____

TIMES AND DOSAGE TO BE TAKEN: _____

_____

LENGTH OF TIME MEDICATION WILL BE REQUIRED: _____

_____	_____	_____
DATE	NAME OF PHYSICIAN	SIGNATURE OF PHYSICIAN

_____	_____	_____
DATE	NAME OF PARENT	SIGNATURE OF PARENT

NOTARY: _____

Date/Stamp/Seal

THIS FORM MUST BE RETURNED TO THE NURSE DURING IN-PROCESSING IF YOUR CHILD REQUIRES MEDICATION WHILE ATTENDING CAMP. DO NOT RETURN WITH MAIN APPLICATION.

THIS FORM MUST BE NOTARIZED !!!!!!!

In case of sudden illness or an accident to the below named participant, requiring immediate treatment or surgery while participating in the NJ National Guard Family Camp Program, I authorize the Primary Staff or Medical Staff to take such action as deemed appropriate to protect the health and physical well-being of my child. This authority extends to any physician(s) and /or surgeons(s) selected by the Primary Staff to perform medical and/or surgical procedures including examination and tests necessary to preserve the life and well-being of my child.

All efforts will be made to contact the parent(s) or guardian(s) in case of an emergency.

Name of child: _____

Parent or Guardian: _____

_____

(Parent or Guardian Signature)

Address: _____

City, State, Zip: _____

Phone Number: _____

Work Number: _____

Cell Phone/Pager Number: _____

Doctors Name: _____

Doctor Phone Number: _____

Notary: _____

Date/Stamp/Seal

*******THE ABOVE MEDICAL EMERGENCY AUTHORIZATION STARTS ON THE FIRST DAY OF CAMP ENTRY OR 12 July 2008 (which ever comes first) AND EXPIRES ON 19 July 2008 UPON THE COMPLETION OF CAMP*******